DIRECT HEALTH CARE PROVIDER PROGRAM
CONTRACT REQUEST FOR FY

DATE:

TO: Commander
North Atlantic Regional Medical Command
ATTN: MCAT-RM
Walter Reed Army Medical Center
Washington, DC 20307-5000

FROM: Commander
U.S. Army Medical Department Activity
ATTN: MCXR-BD-MC
2480 Llewelyn Avenue
Fort George G. Meade, MD 20755-5800

1. Request authorization to ☐ initiate ☐ renew a ☐ local ☐ centralized ☐ personal ☐ non-personal services contract

for _____ for _____ total hours of service
(*Provider specialty and equivalent AOC/MOS)*

to be performed in the _____ at _____
(*Identify workcenter, e.g., EENT Clinic, etc.)* *(Identify facility)*

on a ☐ full time ☐ part time basis, beginning _____ and ending _____.

a. If renewal is being requested, complete paragraph 7 below titled, "Additional Comments."

b. This request is priority number _____ relative to other requests submitted for FY .

2. Estimated cost of the contract is _____. Compensation to the provider will be at a rate of _____ for part time service.

3. Request funding be provided as indicated below:

☐ a. DHCPP Funds (code _____).

☐ b. Reprogramming of _____ fund (code _____) to DHCPP (code _____).

☐ c. Other (specify) _____

☐ d. If DHCPP funds cannot be provided, request authority to contract using local funds.

4. The following data is provided in support of this request:

a. Provision of the above stated service is required as a:
☐ TDA Assigned Mission
☐ Modified Mission
☐ Not a Recognized Mission (*Please explain in item #7)*

b. Present staffing for above stated requirement is:

Position title	AOC/MOS	CC Num, TDA para and line number	Required		Authorized		Assigned	
			Mil	Civ	Mil	Civ	Mil	Civ

(Continue in item # 7 if necessary)

MEDDAC (Ft Meade) Form 669-E
1 Apr 98

This form should be used in the smae manner as HSC Form 542-R. See HSC Suppl 1 to AR 40-1, para 4-4. The proponent is the Managed Care Branch, Business Division.

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c. Justification: (Minimum justification must address the cost effectiveness of contracting versus other available means of acquiring providers, must state that adequate ancillary personnel are available to support the requested physician provider, must confirm that space and equipment adequate to support the provider are available, and must comment on the applicability/availability of alternatives to contracting including shifting of current resources, civilian hires, VA/DOD Health Resources Sharing Agreements, Joint Health Benefits Delivery Program, and supplemental care.)

5. MEDDAC concurrences:

DCCS: *(Name & Telephone Number)*

Force Development: *(Name & Telephone Number)*

Resources Manager: (*Name & Telephone Number)*

Other: *(Name & Telephone Number)*

6. Requesting activity POC is:
(Name, Grade, Position, Office Symbol, and Telephone Number)

7. Additional Comments (reference specific paragraph when appropriate)

Reference para 1:

Date current FY contract awarded:

Date actual performance initiated:

Total manhours contracted:

Total cost of contract:

Funds obligated as of end of 1st Qtr of FY:

Actual hours of service provided as of end of 1st Qtr of FT:

Name, grade, branch, signature and phone of MTF commander/director or designee:	Date: